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Original Articles.

"VENEREAL DISEASE"?

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AND

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TERMS used in an exact science should have real significance expressing definition, differentiation and accuracy, thus enabling one at all familiar with the subject involved to place the term readily in its proper category. This is partly true in the field of medicine, one of the glaring exceptions being syphilis and gonorrhea, two distinct infections which have no common scientific basis in cause, symptoms, treatment, or control. These two diseases survive by common consent as "venereal diseases." Why? Because socially, not scientifically, they are still assumed to have a common factor, a sole cause—immorality.

Infants with ophthalmia neonatorum, or little girls with vaginitis may have a gonorrheal infection but one cannot justly accuse such children of having "venereal disease." Children with hereditary syphilis, adults with tru-

ly accidental extra-genital infections of syphilis (lip, tongue, tonsil or fingers), and the man or woman contracting syphilis or gonorrhea through marital relations, with no illicit action on the part of at least one of the parties involved, should not be put in the class of people suffering from a "venereal disease," remembering that the term is applied only because of its social cause. These people are all suffering with a definite infection of syphilis or gonorrhea, so let us call the diseases by their true scientific names and not by an all too confusing general term.

No educational campaign was ever more effective because of cloudiness of definition used in its publicity. No physician or public health official ever gained the confidence of patient or community by veiling definite facts under general inclusive terms. Courts of justice assume that every human being is legally innocent until he is proven guilty. Why should not every patient infected with syphilis or gonorrhea suffer from a "chronic contagious disease" and be treated in a department for syphilis or a G. U. clinic? Why should they all be suffering from a "venereal disease" and be treated in a venereal disease clinic? These people have a right to their innocence until they have been proven otherwise, and even the most careful investigations may be prejudiced

by the false premise assumed. This is especially true in cases of accidental infections.

Many of the old medical terms and names of diseases have no scientific basis, and are continued in medical nomenclature simply on account of long usage. Venereal disease or "The Venereal" was a term applied to syphilis, chancre, and gonorrhea long before their etiology was known, and many of the best medical men believed they represented only different stages or manifestations of the same infection. This idea remains in some lay minds of the older generation—they still fear that syphilis may develop from neglected gonorrhea. The medical profession as a whole had begun to recognize that no one homogeneous term could satisfactorily cover two diseases having so many scientific and clinical points of variance and involving such widely different medical and social treatment as syphilis and gonorrhea. Social workers and the general public were following close in the lead of the medical profession and it seemed to many of us that a great step had been taken toward a better understanding of the two diseases, both medically and socially, and a clear understanding is the greatest asset in solving a difficulty.

The war has seemingly turned the wheels back again, and we shall but add even more to the general confusion unless we keep always in mind what the Army and Navy mean when they use, as they do constantly, the term "venereal disease." For the use of the term by the Army and Navy presents to them no such confusion as when used by civilians and in relation to civilian matters. Syphilis and gonorrhea are powerful enemies of any army or navy and must be conquered or controlled if the men are to be kept "fit to fight." In this connection it might be said that continence is almost as effective a means of prophylaxis against syphilis and gonorrhea as mosquito bars are against malaria and yellow fever. And there is a certain analogy between the draining of swamps, and the compulsory cleansing of vast numbers of persons whose unchangeable habits of life keep alive in our midst the active agents of disease. Disciplinary methods indispensable to the army are perfectly impracticable as applied to the community at large. Not by merging these two points of view but by keeping them absolutely distinct, can the military and civil authorities

meet on common ground to effect a solution of the problem on a permanent basis.

After men have been accepted for the army and navy there is ample justification for the use of the term "venereal disease." Among the cases of syphilis and gonorrhea which occur in service the source is generally from venereal exposure. It is true that a certain number of men accepted for the army and navy have syphilis or gonorrhea at the time of enlistment but they present to the examining board only a physical or medical problem and are judged as such; the question of how the disease was contracted does not affect the status of men infected *previous* to enrollment. When syphilis and gonorrhea are contracted after enlistment they will be separated in the mind of the commanding officer and attending physicians, and the patient will be treated *medically* according to the diagnosis. But from a purely *military* standpoint a prophylaxis must be outlined with the same end in view as would be the case if malaria or yellow fever were being combated, and it becomes largely a problem of preventing or minimizing exposure and new infections. The solution involves health talks, moving pictures, rules, regulations, courts-martial, deranking of officers, establishment of camp zones, and bills before Congress for the purpose of making these military measures universal in effectiveness rather than sporadic and spasmodic. A large part of the work of the War Department Commission of Training Camp Activities and many branches of civilian war work are directly aimed at preventing any increase in the amount of actual venereal exposure in the army and navy, in the repression of prostitution, and in a cleaner civilian population. Reports coming from the American Expeditionary Forces in France and elsewhere—and based on first-hand information—tell us that on the whole, among our men at the front there are fewer fresh infections of syphilis and gonorrhea than would be found among the same number of men in civilian life.

Let the Government, then, attack this question from a military standpoint as a venereal disease problem, remembering that from a medical angle it has no such common classification, but is based on truly scientific distinctions which demand different treatment both medically and socially. But let us continually guard

against using terms in war times which will add to the confusion in the peace time to come. All health campaigns and educational work should be carried on with this clearly in mind. The more work we can do in time of war on a firm peace time basis, the greater real progress will be made. Let civilian educational work go on with renewed vigor among men and women alike on a simple scientific basis, grouping syphilis and gonorrhea only as two distinctly characteristic and symptomatic infectious diseases to be treated as such for the sake of both patient and community, and do away as rapidly as possible among civilians with the falsely accusing homogeneous term "Venereal Disease."

Selected Papers.

RODENT ULCER.*

BY WALLACE BEATTY, M.D., DUBLIN, IRELAND.

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THE origin and nature of rodent ulcer are still matters of controversy. In my work in the Dermatological Department of the Adelaide Hospital I have met with a considerable number of cases of rodent ulcer, and have found it hard to explain some of its features, more especially in contrast between the clinical history and the histological findings. As far as I am aware, this subject has not hitherto been brought before the Academy, yet it presents many points of interest clinically, pathologically, and therapeutically, which seem to be worthy of discussion by us here, and, indeed, the subject ought to be specially pleasing to us, as the first accurate clinical picture of rodent ulcer was given by Dr. Arthur Jacob, of Dublin, in 1827. In *The Practitioner* of July, 1915, Dr. Graham Little gave an excellent account of rodent ulcer. I have found this account very helpful in preparing this communication. I hope the members of the Academy will pardon me for describing the clinical symptoms and anatomy—so familiar to us all. I do so in order better to lead up to the question of the origin and nature of rodent ulcer.

Rodent ulcer is, in the majority of cases,

limited in position to the upper half of the face, especially the neighborhood of the eyes and nose. But it may occur on other parts of the body. It has two stages: a non-ulcerated and an ulcerated stage. It begins usually as a smooth nodule, firm, and of pearly or waxy translucence. It may be extremely small at first, the size of millet seed, and projecting very slightly above the surface. It increases slowly, and reaches the diameter of a pea or shilling. It tends to become umbilicated. The raised edge may present a granular aspect—mammillated—and fine venous ramifications may be seen coursing over it. This is the early, first, or non-ulcerated stage. The average duration of this stage is from three to six years, but it may be much longer. There is no peripheral inflammation. Sooner or later ulceration commences in the center, while the margin is raised, firm, and of pearly lustre. The ulcerated surface is usually covered by a crust. It readily bleeds when rubbed.

The essential characters of rodent ulcer are:—

- (1) Slowness of progress. A small rodent ulcer may have had already a duration of many years—five, ten, or more.
- (2) Margin raised, firm convex (so-called rolled), of glossy or mother-of-pearl appearance; a circular ridge. In extremely small rodent ulcers the margin may be extremely thin, $\frac{1}{2}$ to 1 millimetre in breadth, but even when of such extreme tenuity its firm, glossy, pearly appearance is characteristic. Small nodular thickenings may extend from the border.
- (3) Non-involvement of the lymphatic glands.
- (4) Absence of pain except in later stages.

The extremely slow progress, the firm mother-of-pearl border, and the non-involvement of the lymphatic glands differentiate rodent ulcer from squamous-celled cutaneous epithelioma. It may begin as early as the age of twenty (this is very rare), or as late as eighty. It often commences at about the age of forty. It appears to be rather more common in men than in women. Some observers have met with the reverse in their statistics. Of 52 hospital cases of which I have records there were 15 males and 37 females. Rodent ulcer may be single or multiple. Multiple rodent ulcers have to be differentiated from Brooke's "Epithe-

* Read before the Section of Medicine in the Royal Academy of Medicine in Ireland. Reprinted from *The Medical Press* of Aug. 7, 1918.

lioma Adenoides Cysticum." Graham Little considers Brooke's tumor to be rodent ulcer. Rodent ulcers, after remaining superficial for years, may take on deep action and lead to hideous deformity. Thus rodent ulcer, beginning near the eye, may later involve the eye itself and the orbit. Sometimes the ulceration involves the whole area affected; in this case there will be no "rolled" pearly edge, but the ulceration is bordered by a fine excavated margin, a shallow, extremely narrow, marginal excavation. Such a condition is met with on the forehead and spreading over the front of the scalp, and may involve a considerable area. It may cicatrize in part, and may cause death if it takes on deep destructive action and leads to involvement of vital organs or to hemorrhage.

Histology. . . . (cf. Unna's Histopathology). I quote Unna's description: "There is in the early stage a very circumscribed thickening of the prickle layer, which raises and smooths the horny layer. The horny layer is very little thickened. From the base of the prickle layer there is a downward extension of a few cylindrical epithelial processes; these processes are connected with the epidermis by a small neck. These processes widen a little, wind laterally or round one another, and terminate in the middle of the cutis. They are surrounded by a broad wall of plasmona (plasma cells).

"The interepithelial connective tissue, i.e., the tissue between the epithelial columns, becomes increased—swollen and multiplied spindle cells are found—a new formation of fibrous tissues takes place. Very slowly the cylindrical processes extend into the thickened connective tissue. The processes twist and wind in a most complicated manner; when their advance is arrested they send off lateral processes. Thus the tumor presents a reticulated character. The growth always remains flat.

"The cells inside the epithelial processes (columns) are altered in shape owing to the abnormal density of the connective tissue around. These central cells of the processes become elongated—spindle and rod shaped. The peripheral cells of the processes are exceptionally cubical (never cylindrical); they may be spindle-shaped. While the epithelial processes are ever increasing they never completely run together, but are always separated by firm connective tissue.

"In the second, ulcerated stage, the ulcer-

ation takes place very slowly and superficially, and there is a tendency to 'skinning over' by spreading over the epithelium from the periphery. So in many places it would appear as if the old epidermis still clothed the ulcer."

Unna explains the indolence, long duration, and resistance of rodent ulcer by: (1) the resistance of the connective tissue; (2) the tendency to skinning over. Unna adds: "When, as sometimes happens after the rodent ulcer has remained superficial for many years, it begins to involve the depth, the special character disappears, and the growth resembles the ordinary ingrowing cancers. This is due to degeneration of the connective tissue, which becomes edematous, and no longer offers a barrier to the spread of the epithelium. Thus the scirrhus type of the rodent becomes changed into the medullary type of cancer." This may be regarded as the third or final stage of rodent ulcer.

There is much difference of opinion among pathologists as to the origin of rodent ulcer. The cells which form the epithelial columns are smaller than the cells of an ordinary epithelioma, are not united by prickles, and do not become horny. There are three different views as to the origin of these cells:

(a) Derived from the surface epithelium. This view is the one Unna adopts, as is described above. The difficulties about this view are:

(1) There is difficulty in finding a connection between the epithelial columns of the tumor and the surface. This connection, however may usually be found if careful serial vertical sections of the tumor are made.

(2) If the cells are derived from the surface epithelium, why do they not tend to complete their evolution and become horny?

A view has been put forward that the origin of rodent ulcer is from the basal cells of the epidermis, and not, as in ordinary epithelioma, from the cells higher up. According to this view, rodent ulcer is a carcinoma basocellulare. This view appears to me very fanciful (Malory considers it absurd!). It appears to me fanciful to conclude that from the surface epithelium there are two kinds of epitheliomata, one starting from the basal layer of the rete mucosum (rodent ulcer); the other from the higher, more differentiated prickle cells about to become horny (squamous-celled epithelioma).

In health the only cells of the epidermis

which proliferate are the basal cells of the rete mucosum, the so-called germinal layer. These alone show the proof of proliferation—viz., mitoses of the nuclei. These basal cells are, therefore, in health, the mother-cells of the horny layer, i.e., these cells complete their evolution by becoming horny. Why should they not do this in rodent ulcer? No doubt in epithelioma mitoses are found in the higher prickle cell layers as well as in the basal layer. But this only shows the enormous activity of the prickle cells generally in epithelioma. (b) Derived from the epithelium of the sweat glands. A cylindrical carcinoma. (c) Derived from the cells of the hair-matrix. A hair-matrix carcinoma. This view is held by Mallory (cf. his "Principles of Pathologic Histology").

Mallory writes: "The cells which arise from a hair-matrix and from the hair and its sheath do not differentiate except to a slight degree, in the way that the cells of the epidermis do. Tumors arise not infrequently from hair-matrices; the cells composing them tend to differentiate in the same way as do the cells normally arising from these structures. The cells are characterized by their cubical cylindrical or spindle shape, their small amount of cytoplasm, and their intimate relation to each other, etc. The tumor usually grows slowly. It may spread widely in the corium and form connection with the overlying epidermis at many points," etc. Mallory, it will be observed, explains the elongated shape of the cells in the epithelial columns from their origin, and not from pressure of the intervening connective tissue.

I confess I find it difficult to accept the hair-matrix origin of rodent ulcer, or that cells arising independently from the depth could, growing up, form a perfect connection with the epidermic cells. Yet it is difficult to account for the smaller size of the cells as compared with those of an ordinary epithelioma, the absence of prickles, and the absence of keratinization. It is interesting to compare the character of the epithelium with that in soft nevi. In the latter the cells, undoubtedly of surface origin, have, owing to a change called by Unna metaplasia, lost their prickles, and extend into the cutis in columns or strands or streams, losing in many places their connection with the prickle cells of the surface. I shall refer to this presently.

If one regards rodent ulcer as a carcinoma, the contrast between the rapid growth of ordinary epithelioma and the slow progress of rodent ulcer may be explained thus. There is through life a continuous conflict between growing epithelium on the one hand and the adjacent connective tissue on the other. In health a balance is maintained. As age increases epithelium tends to increase. If the connective tissue maintains its power of resistance the epithelium can increase only at the surface, e.g., warts, senile keratosis. In rodent ulcer the connective tissue has begun to give way, but only in places. But it offers considerable opposition, hypertrophying, and only allowing the epithelium to grow in narrow cords or columns of varying thickness, which form a kind of acinous arrangement or network through the connective tissue. The resistance of the connective tissue is extremely great at the surface, so that the epithelium can penetrate only in a very few places and in very narrow cords. Hence the difficulty in finding a connection in sections between the epithelial columns of the tumor and the surface epithelium. In ordinary epitheliomata the resistance of the connective tissue is practically nil. The epithelium makes its way unopposed into the connective tissue and lymph cells, and many cells complete their evolution, and become horny.

It is difficult to understand why the cells of a rodent ulcer, which multiply much more slowly, should be without prickles and should not keratinize. It is noteworthy that when a rodent ulcer, after years of slow progress, begins to penetrate deeply, it may assume the ordinary character of a squamous-celled epithelioma. Then the resistance of the connective tissue is lost, owing to degenerative changes.

Epithelioma Adenoides Cysticum (Brooke). Side by side with rodent ulcer it is well to consider this affection, clinically so unlike, histologically so like, rodent ulcer. Some, including Graham Little, consider it a form of multiple rodent ulcer. Unna places it side by side with syringadenoma (i.e., adenoma of the sweat ducts), and gives a careful account of the differential diagnosis between these two affections. I give Unna's description: "It consists of multiple small pinhead to pea-sized shining nodules; at first of color of the skin, later pale yellow or bluish, some containing

milium-like insertions (Unna). It has a predilection for the region of the eyelids, root and alae of nose, adjacent part of cheek, and surroundings of mouth."

Histological Examination. Solid epithelial processes derived from the surface epithelium or from the prickly layer of the lanugo hair follicles grow into cutis in the form of finger-like processes, glandular protuberances, net-like or lattice-like pattern, completely solid cones. It affects the entire cutis. The epithelial masses are bordered by palisade (cylindrical) cells. There is round the cell masses an abundance of cellular connective tissue. Cysts, colloid or hyaline, are present, surrounded by epithelial masses. These are due to epithelial degeneration.

One may find a solitary tumor with the same structure, just as one may find a solitary tumor with the same structure as that of multiple hidradenoma. Cases of epithelioma adenoides cysticum of Brook, have been described under other names. Thus, Perry's case of "adenoma of sweat glands" is an example (see "International Atlas of Rare Skin Diseases"). Unna, in the supposition that the cells of the tumor are connected by prickles, calls Brooke's disease "acanthoma adenoides cysticum."

To Recapitulate. How are we to explain: (1) the extremely slow progress of rodent ulcer; (2) the smaller size of the cells, the absence of prickles, and the absence of keratinization as compared with an ordinary epithelioma?

The Slow Progress. Rodent ulcer is clinically non-malignant; a rodent ulcer untreated may remain small for many years. If it is a carcinoma, whether derived from the surface epithelium, the epithelium of the hair follicle, or the epithelium of the sweat glands, why is it so slow in its growth? Is this altogether due to the opposition to its growth offered by the connective tissue?

The Character of the Cells. If the sweat gland origin of the growth be adopted, the character of the cells is explained, but, as just said, why the little malignancy? The view that has been suggested, that rodent ulcer is of nevus nature, may now be considered. The word "nevus" is used in a broad sense. "A congenital alteration in the color or texture of the skin of limited extent, benign, appearing at birth or developing later" (a French

definition). I confess this nevus nature idea appeals to me, and would explain many difficulties: (1) The extreme chronicity; (2) the unusual character of the cells as compared with those of an ordinary epithelioma. I offer a suggestion—it may be extremely fanciful, it is this. In soft moles we see columns or streams of cells more or less broken up by collagen fibers. Unna has proved these to be of epithelial origin. These cells are derived from the epithelium of the surface, but have lost their prickles by a change which he calls metaplasia.

Is a rodent ulcer an epithelial growth, starting from a microscopic soft nevus, present at birth, and developing later; and is its reticular form due to the presence of the fully-formed connective tissue, the columns of cells making their way as best they can? Brodie has suggested the mole origin.* Still another fanciful idea. Sweat glands are formed in embryonic life by downward projections from the epidermis. The cells of sweat glands never become horny. Might the streams and columns of cells in soft nevi (moles) be abortive supernumerary sweat glands? From this we could have a transition to the tumor known as hidradenoma, and to rodent ulcer and to epithelioma adenoides cysticum, or, as some would have it, cystic rodent ulcer. In this case rodent ulcer would be a nevus of the sweat glands. When a rodent ulcer takes on malignant action, what has happened? Is it still simply a rodent ulcer, or has it become complicated with an ordinary epithelioma? A rodent ulcer epitheliomatized! And when, exceptionally, in a rodent ulcer some horny cell nests are found, is the rodent ulcer similarly complicated? When treatment of a rodent ulcer fails to cure, its growth may be hastened; for example, after repeated x-raying, after repeated application of radium, or after unsuccessful excision. Has the rodent ulcer then, from irritation, become epitheliomatized?

THE TREATMENT OF RODENT ULCER.

I shall make only a few remarks on treatment. The following are the methods of treatment adopted in different cases:

(a) *Excision.* As the majority of rodent ul-

* Adamson is inclined to regard rodent ulcer as of nervous nature.

cers are on the face, this plan can be adopted only when the lesion is small, and can be completely removed without a disfiguring cicatrix. Recurrence, even in small tumors, after excision, is frequent. I met with a pea-sized rodent ulcer below the mastoid process which was widely excised by Mr. Gordon, and yet it recurred soon after, and was cured lastingly by x-rays.

(b) *Ionization.* Ionization by zinc ions is a good treatment, but it is painful, and has to be repeated frequently.

(c) *X-rays.* Sabouraud recommends a full Sabouraud pastille dose every 18 days for six times. X-rays are often successful; even one full pastille dose may be sufficient, but often a much greater number than six may be needed. Graham Little refers to a case eventually cured after 95 applications of the rays. He does not mention, however, what the dose was in each case. Sabouraud's plan is a good one, but if the rodent ulcer is not cured by six applications, according to his method, it will be advisable to space further administrations of the rays over a longer interval—five to six weeks. Some authors recommend one single massive dose of the x-rays, viz., three full Sabouraud pastille doses at once. I have no personal experience of this method.

(d) *Carbon Dioxide Snow.* The treatment by carbon dioxide snow (temperature, 79° F. below zero) is often extremely useful. The snow is applied under firm pressure for twenty or thirty seconds. A vesicle or bulla forms in a few hours, and in the course of some days dries into a crust. The crust may remain adherent for a fortnight. One application may cure, but a repetition may be necessary, and is always safe.

NOTE.—I have omitted to mention treatment by radium, as I have no *personal* knowledge of its value in rodent ulcer. Indeed, I have said very little about treatment, as the main object of my paper is to discuss the origin and nature of rodent ulcer.

Society Report.

ABSTRACT OF THE PROCEEDINGS OF THE FORTIETH ANNUAL CONGRESS OF THE AMERICAN LARYNGOLOGICAL ASSOCIATION, HELD AT ATLANTIC CITY, NEW JERSEY, MAY 27-29, 1918.

BY EMIL MAYER, M.D., NEW YORK, ABSTRACT EDITOR.

THE president, Dr. Thomas H. Halsted, Syracuse, New York, called attention to the fact of this fortieth anniversary comprising practically the whole period of modern laryngology.

He paid a tribute to the memory of Dr. E. Fletcher Ingals, a founder of the Association, who died but a few days before the meeting, and who remained to the last an Active Fellow, furnishing last year one of the most valuable papers of the meeting.

He welcomed, also, Dr. H. S. Birkett of Montreal, one of the Fellows of the Association who, responding promptly to his country's call, had spent nearly four years in active service, rising to the highest rank and responsibility.

Each Fellow of this Association feels a personal pride in these achievements.

Of an active membership of eighty-two, 30% are in the active Naval and Military Service of the United States, which is a very creditable showing, considering the average age of its Fellows.

The speaker then presented for the subject of his address:

A DIAGNOSTIC CLINIC FOR PAY PATIENTS.

While organization of hospitals for the care of ward cases and dispensaries for free ambulatory cases have been well organized, there has been no combined arrangement for the care of private patients, hence it frequently happens that a diagnosis cannot be made because of the expense involved in calling in as many physicians as the case really demands.

Ofttimes the patient seeks relief by consulting various physicians of his own volition, producing disappointing results.

It sometimes happens that the right physician is accidentally consulted, and the cause of the obscure symptoms found, with a resulting cure.

It is for the profession to devise the means of correcting this very grave fault. As a re-

sult, there have arisen many institutions where the medical staff is composed largely of specialists of different branches. While some of these institutions are excellent in every way, the great majority are not of this character, and as long as they are purely commercial organizations they never will be.

The speaker said that the scheme devised, worked out and practised for nearly three years by the Clinical Club of St. Luke's Hospital, San Francisco, offered the best foundation from which to build a diagnostic clinic, and that it had met this particular situation.

The medical staff of this hospital consists of twenty-four full staff members, four consultants and ten assistants, with an excellent clinical laboratory and complete x-ray department.

In the hospital to which the speaker is attached, the first choice was given the regular staff, after which the assistants were given an opportunity when vacancies arose. The staff was divided into two groups, serving on alternate months, with a third group, known as the auxiliary group, made up of those specialists whose services would not be required in every case. The latter become available in any case in which the group chairman thinks such service desirable.

The chairman is responsible for the history of the case, and after his examination is made, arranges for the visits of the other members of the group, together with such members of the auxiliary group as he may desire. A supervising nurse keeps the records and attends to the financial end of the work, sees that specimens are furnished the laboratory, arranges the details of the physician's visits, is present at all examinations, typewrites the notes and attends the general consultations, taking the minutes and transcribing them.

After all examinations, clinical and laboratory, have been completed, a general consultation of all who have had to do with the case is held, and every possible diagnosis arrived at, the physician referring the case being present and participating in the consultation.

A satisfactory conclusion having been reached, a report is sent to the referring physician, a second copy to the patient or his responsible relative whenever this seems desirable, and a third retained in the files of the clinic.

Only cases that are obscure and complicated, and apparently cannot be diagnosed by the average physician, are accepted by the clinic.

A minimum fee of \$50.00 and graded upward, according to the patient's financial situation, is charged. Such fee includes the services of the medical man and of the laboratory and x-ray departments, as well as of the supervising nurse. In addition, the hospital charges regular room rates for time occupied.

The portion of the fee remaining will be finally divided equally among those who have examined the case, to be received by them individually or be voted by them for the purchase of new equipment for improving the service of the clinic of the hospital, the latter being expected to be the disposition of the funds for some time to come.

In rendering this service they will themselves receive much knowledge and should benefit greatly through these examinations and consultations, adding materially to their diagnostic ability.

The hospital will benefit by the steadily increasing efficiency of its staff.

Finally, the speaker called attention to the work of its committee in the National Council of War Defense, and requested a quick response to the appeal of the Surgeon-General for voluntary medical service to meet the demands of the drafted army.

Each man must weigh the matter for himself, and putting aside any argument and all questions of personal advantage, reach a decision that he will be willing to submit to the scrutiny of his fellows, and abide by their decision. Those who can go are to be congratulated; they are to be envied; they are the favored ones of the profession. A doctor who in this emergency can conscientiously go and fails to respond to his conscience and his country's call, putting a selfish profit first, is not to be envied but to be pitied.

To commemorate the fortieth anniversary of this Society, a historical review of the early days of laryngology was read by the honorary president, Dr. J. Solis Cohen of Philadelphia, followed by Dr. D. Bryson Delavan of New York.

The scientific program then followed with the papers and discussions here presented.

REPORT OF SOME INTERESTING CASES OF VINCENT'S ANGINA.

CLEMENT F. THEISEN, M.D., ALBANY.

There are two distinct clinical types of the disease, one form to be differentiated from

diphtheria and other pseudo-membranous anginas occurring almost exclusively in young people, while the other form has a localized ulceration, simulating syphilis, occurring mainly in adults, usually, in the writer's experience, associated with carious teeth, especially in those whose mouths are not well cared for.

The odor is distinctive and characteristic, and if not promptly treated, extensive ulceration of the fauces occurs, with fatal ending.

The writer has had two fatal cases,—one previously reported in 1912, and the other a recent case in a man thirty-two years of age. The uvula and part of the soft palate had been practically destroyed, and there was deep ulceration of both tonsillar surfaces and of the gums around the last molars. The ulcerated surfaces were covered with a tenacious pseudo-membrane. The molar teeth were badly decayed, and the gums bled easily when touched with a probe. The odor was so bad that it required a good deal of courage to examine him. He said the condition had been going on for several weeks, and he had received no treatment. He had been using a mouth wash of peroxid and water.

He was in an extremely weakened condition, because the pain in swallowing was so severe that he had not been able to take much nourishment. No history of syphilis could be obtained. Smears from throat swabs verified the diagnosis of Vincent's angina.

He was given a strong solution of potassium chlorate, powdered alum, carbolic acid, glycerin and water, to be used as a gargle, and locally the ulcerated surfaces after cleaning were swabbed with a saturated solution of methylene blue in alcohol. He was given K.I. in large doses. This is always administered in the writer's cases, whether a history of syphilis is obtained or not. Blood count showed a moderate leucocytosis. He failed steadily in spite of all efforts, and died about two weeks after he was first seen. The larynx was not involved in this case.

Salvarsan was used both locally and intravenously without any appreciable effect. No autopsy.

Pure alcohol swabbed on the ulcerated surfaces is also extremely valuable. The greatest difficulty is in having the severe cases get enough nourishment, because the pain in swallowing is often so great. A solution of orthoform in olive oil, swabbed on the ulcerated sur-

faces before meals, affords a certain amount of relief. A spray of carbolic cocain in the worst cases gives more relief than anything else, if used a few minutes before meals. In some of the adult cases of the ulcerative type we are probably dealing with a combination of syphilis and Vincent's, even when we fail to obtain a history of syphilis. That may be one reason why salvarsan acts so promptly in some cases, although the consensus of opinion would seem to prove that the arsenic preparations do have a specific action. He has known cases of this kind in which there was a positive Wassermann (with no syphilitic history), with the typical clinical and microscopic evidence of Vincent's.

DISCUSSION.

DR. CHRISTIAN R. HOLMES, Cincinnati: I should like to ask as to the temperature of the patients; whether blood cultures were made in the two severe cases, and how he used the alcohol treatment—by applying it locally or not. In Camp Sherman we had quite a run of Vincent's angina in the soldiers; but none of them was seriously ill. All were the kind of cases that yield readily to treatment.

The treatment was nitrate of silver bead applied in the crypts, using it on a heavy silver wire, the patients using gargles of permanganate of potash and peroxid of hydrogen. Gargling with vinegar diluted with equal parts of water was tried lately and appeared very effective.

DR. LEWIS A. COFFIN, New York City: We have had many papers on this subject. From these it is evident that patients have gotten well under various forms of treatment. It strikes me, therefore, that if these cases are seen early, recovery may be looked for, if any of the various methods be applied vigorously. The speaker referred to a case which he treated twice daily for about a week, when he told the patient that he was practically well and need not return for forty-eight hours. The same afternoon, after sitting out during a ball game, he was seized by a chill, which was the ushering-in symptom of a typical attack of follicular tonsillitis.

COL. HERBERT S. BIRKETT, M.D., Montreal, Canada: Perhaps there is no condition which is more prevalent than Vincent's angina among British troops. I seldom saw it in any of the

colonial troops, and this, I think, arises from the fact that the mouth conditions are very well cared for amongst the Canadians. The condition was found not only on the tonsils but also on the gums, even as far forward as the incisor teeth; it would seem as if this was due rather to direct infection. My experience with this condition is that it yielded rapidly to treatment, consisting of an application of hydrogen peroxid, liquor arsenicalis and vin ipecac.

DR. EMIL MAYER, New York City: It is relatively easy to make a diagnosis of Vincent's angina when there is an exudate and you can make a smear; but I saw some days ago an instance in which the diagnosis comes to me as a very great surprise. This was in the case of a lady who took good care of her teeth, and was a woman of much refinement. She consulted me on account of a spasmodic cough. She had a skin affection for which she was being treated. I saw a simple mild exudate on her soft palate, which I felt to be an evidence of the skin infection on her mucous membrane. I felt that she had a similar condition on her trachea, because of the negative result of all of the examinations. Her sputum was really more saliva than anything else; and I was intensely surprised at the report that it was full of the fusiform bacilli. There was an absence of anything like a membrane, yet the condition occurred, and in a person not neglectful of her teeth or anything else; so it probably occurs much more frequently than we really have a right to expect in this class of cases.

The treatment that has answered best for me has been the local application of salvarsan, together with the iodine and glycerin, which I recommended at the time the first case was reported by myself in the English literature. I have never seen the severe fatal cases. Arrow-smith reported a case in which the patient nearly died. I think that it behooves us to be on watch, because we may probably discover cases where we do not dream of them.

DR. GREENFIELD SLUDER, St. Louis: Dr. Theisen spoke of a solution of methylene blue in alcohol alone. I am glad to know that; but I have also used the methylene blue in powder and in aqueous solution, and likewise found it to answer the purpose.

DR. CLEMENT F. THEISEN, Albany, closing: Replying to Dr. Holmes' question regarding

blood cultures, I would say that we did not take blood cultures, but we took blood counts; and the leucocytes in both cases were increased. I forgot to mention the increase in the polynuclears, and also to mention a method of treatment—a combination of old drugs which is practically a specific, either as a gargle or in the spray form. This combination consists of potassium chlorate, powdered alum, glycerin and water. It works like a charm. The alcohol is used locally.

REPORT OF SOME CASES, MOSTLY TRAUMATIC, OF SERIOUS DAMAGE TO THE NOSE AND ACCESSORY SINUSES, OPERATED UPON EXTERNALLY, WITH EXCELLENT COSMETIC RESULTS.

JOHN R. WINSLOW, M.D., BALTIMORE.

The writer reports a number of cases of operative cure after serious injury to the face:

1. Extensive traumatism of the nose, face and frontal sinuses due to a fall from a height. Operative cure with exceptional result.

2. Frontal empyema with extensive bone necrosis and external fistula, operated upon externally in several sittings. Cure of condition, with excellent cosmetic result.

Several interesting points were presented by this case:

(a) Lack of intranasal pathologic conditions. A virulent infection (erysipelas?) seemed to have attacked the frontal sinus and uppermost portion of the bony framework of the nose without involvement of other nasal sinuses.

(b) The posterior (cerebral) sinus wall was denuded, but was hard and seemed devitalized rather than necrotic. It took a very long time for it to regenerate (twenty-six months), but his own judgment and the advice of colleagues was that it was better to delay than to assume the risk of removal.

(c) Marked anesthesia of the operative field, the packing being for a long time painless, doubtless due to the devitalized bone.

(d) Excellent cosmetic results.

3. Fracture of the external bony framework of the nose and the nasal septum by the kick of a mule, causing depression of the tip of the nose and great disfigurement. Restoration of appearance and function by operation.

4. Fracture of the right nasal bone and nasal process and a portion of the orbital process, by an iron rod; formation of sequestra and abscess, with secondary infection of the right

antrum. Operation and cure, with good cosmetic result. Photographs showing their excellent results were presented.

DISCUSSION.

DR. JOHN E. WINSLOW, Baltimore: I should like to hear from Dr. Coakley or some of the other experts, as to the proper plan of treatment under such conditions as I have described, where there is necrosis of the cerebral wall of the frontal sinus. How long are we justified in waiting for nature to attend to it? Did I wait too long, or was I too conservative?

DR. CORNELIUS COAKLEY, New York City: When I have operated on the frontal sinus I have never found actual necrosis of the wall unless there had been syphilis. It is unusual for me to find such a condition. What I have found is that in cases that have been operated on previously, there has been a temporary cessation of the discharge with fistula formation. When I have opened up the frontal sinus in these cases it has not been infrequent to find areas of very marked softening in the bone, such as one finds in a mastoid operation at the border, when one has gotten back of where the large cells are and comes to the cells just between these and the cancellous bone. I think that there is no reason why that bone should not be regarded as infected bone, just as in the mastoid region; and I feel that neglect to clean out this diseased bone and get down to healthy bone, whether in the anterior wall or anywhere else, is not good surgery. You should get to good bone, even if you expose the dura in the frontal region.

In one instance I found such a degree of softening of the posterior wall that I felt sure that I should find exposure of the dura and epidural abscess. Fortunately, however, that was not the case. I went through an area of three-eighths of an inch of vascular soft bone before coming to what must have been a very thin area of good bone at the posterior wall of the frontal sinus. The soft bone was all cleared out. A drain was placed in the wound for a short time, leading to the nose. The wound was sewed up, as in the ordinary Killian operation, and the patient has made—temporarily at least—a good recovery. The operation was done three months ago, and up to the present time there has been no recurrence, although there were two or three before that. Soft or diseased bone, or any other bad bone in the frontal sinus, should be treated just as you

are in the habit of treating the same kind of bone in the mastoid or any other region.

DR. LEWIS A. COFFIN, New York City: I should be much less afraid of a curette than of leaving diseased bone in a patient. As to whether the posterior wall being necrotic and perforated is an invariable sign of syphilis, I have grave doubts. I have seen this condition in comparatively few cases; one case was in a child of six years having perfectly healthy parents. In reporting that case I spoke of another that I had previously seen in which the anterior wall was so soft that I removed it with a spoon curette, and stated that I did not see why the posterior wall should not be affected by the same pathologic process as the anterior wall. A case somewhat similar to the one just reported comes to mind. A young woman was riding in an automobile when the peculiar accident happened. The shaft of a wagon to which a horse was attached entered the antrum through the middle of her cheek, fracturing the floor of the orbit and the antero-nasal wall. She had been under treatment for some time when I saw her. Removing a pad of gauze from her face revealed a stream of pus pouring from the open wound in her cheek. I made an incision over the eyebrow down over the ridge of the nose and the center of the skin, covering the columnar cartilage and dividing the upper lip in the median line. Turning the flap well back gave a good exposure of all the diseased parts, which were thoroughly cleared out. We and our patients are fortunate in the kindly way in which incisions of the face heal. In this case there was practically no scarring except where the shaft of the wagon pierced the cheek.

DR. GEORGE L. RICHARDS, Fall River, Mass.: The ability of the face to heal is very remarkable. I recall that some years ago I had a patient who was riding a bicycle down a hillside when the chain broke, and he was pitched suddenly forward in such a way that he tore off the front of the face from the nose to the chin, and in addition got all the dirt of the street into his wounds. A number of operations were necessary, but in the end a fairly good-looking face resulted.

DR. T. PASSMORE BERENS, New York City: It seems to me that this is the same condition that we find in the mastoid of bone that is not syphilitic, but is simply an unusually firm, hard bone. We have to be patient, and let it heal.

A number of years ago I mentioned the mild pressure that was needed in these cases, such as would come from a pince nez with long horns pressing the nasal bones together. It seems to me that if he had exerted a slight constant pressure, such as you get from a pince nez, he would have overcome that broadening of the nose. I merely mention this to accentuate the benefit of constant mild pressure.

DR. BRYSON DELEVAN, New York City: In suppurative conditions of the nasal sinuses if there should be any question of the existence of syphilis, operative work must be undertaken with caution, since under antisiphilitic treatment many cases have been cured or have satisfactorily improved without operative interference. Many cases could be quoted to prove this. It may be said, therefore, that where there is a positive Wassermann reaction wait, if possible, until a course of specific treatment has either cured the sinus disease or made the necessity for operation clear.

DR. JOHN R. WINSLOW, Baltimore, closing: I do not want to leave anyone under the impression that I am ignorant enough to leave soft bone and close it in the wound. It was not soft, but hard as steel, and I curetted it three times as much as I thought was safe. I acted not only on my own best judgment, but also on the advice of several friends.

CARPET TACK IN THE RIGHT BRONCHIAL TUBE OF A PATIENT FOR TWO YEARS WITH NO PATHOLOGIC SYMPTOMS. EXHIBITION OF PLATES.

DUNBAR ROY, M.D., ATLANTA.

This occurred in a female aged twenty-eight years. X-ray showed the tack in the right bronchus between the seventh and eighth ribs. Its removal was at once attempted by upper bronchoscopy, and failed. Tracheotomy was performed the next day, the bronchoscope passed, but he was unable to grasp and dislodge the tack, and the tracheotomy wound allowed to heal.

Five months later a bronchoscope was easily introduced by upper bronchoscopy by Dr. R. C. Lynch. The tube was too short and the foreign body could not be removed.

The patient has been entirely well since then, now two years, increasing in weight. X-ray photographs were shown showing the tack still *in situ*.

The writer presents records of a number of cases of this character, many of them without producing untoward symptoms.

DISCUSSION.

DR. T. H. HALSTED, Syracuse: In connection with this case of Dr. Roy's, I should like to report the recent removal of a foreign body from the right bronchus occurring in a girl of ten years. This child, while playing, having occasion to put her pocket handkerchief to her mouth, inhaled a metal clip, shaped somewhat like a fish hook, which had been in her pocket. There was an immediate attack of dyspnea, lasting a few moments, but within a few minutes no symptoms, beyond a sensation as of something sharp lodged in the throat, remained. A physician saw her within ten minutes, at which time all symptoms had disappeared, beyond the pricking sensation. He assured her that she must either have expectorated or swallowed it. She had no trouble that night, but the next morning, the sticking sensation referred to the neck continuing, she consulted another physician, Dr. Swift, who had an x-ray made. This disclosed a foreign body in the right bronchus. She was referred to me for operation. Under general anesthesia I soon located the metallic object by upper bronchoscopy and made repeated but unsuccessful efforts at removal. The x-ray failed to tell whether the sharp point was directed up or down, and it could not be determined by direct inspection. The next morning stereoscopic plates were made, and showed the foreign body to be in the right bronchus, sharp point upward. Under ether, the trachea was opened, and under lower bronchoscopy the foreign body was, after two hours' work, removed. It was in the second division of the bronchus, firmly wedged, but by manipulation it was finally removed by a long alligator forceps with but little damage to the bronchioles. It was a flexible steel clip used in clothing stores for holding cardboard pricemarks, shaped like a sharply bent fish hook, the shaft being three-fourths of an inch long and the pin portion half an inch. It, together with the stereoscopic plates, are presented for examination. The tracheal wound was at once closed, the child made an uneventful recovery, leaving the hospital in eight days. It was the most difficult case of its kind I have met with.

(To be continued.)

Book Reviews.

Immune Sera. By CHARLES BOLDUAN, M.D., and JOHN KOOPMAN, B.S. New York: John Wiley & Sons, Inc. 1917.

"Immune Sera" deals with certain antibodies which have aroused a great deal of scientific interest: Hemolysins, cytotoxins, precipitins, antitoxins, agglutinins and opsonins, snake venoms and their antisera, anaphylaxis and bacterial vaccines. The side-chain theory of Ehrlich and its heuristic value are discussed, and the points are given wherein he and other investigators differ. The purpose of the book is to present the main facts and theories concerning infection and immunity.

A Chemical Sign of Life. By SHIRO TASHIRO. Chicago: The University of Chicago Press. 1917.

This volume presents a chemical method for testing vitality, for distinguishing living tissue from dead, and for measuring the quantity of life. The author applies to living processes in general the facts discovered by the study of nerve physiology; the basis of the functional changes of the nerve mechanism is chemical, and exists in all forms of living matter. Irritability is a sign of life, and can be measured by the increased metabolism which occurs on stimulation. The book includes a detailed method of using the biometer, a machine specially devised for testing the degree of vitality of a tissue by determining very minute amounts of carbon dioxide.

City Milk Supply. By HORATIO NEWTON PARKER. New York: McGraw-Hill Book Co., Inc. 1917. First edition.

This volume offers valuable information about milk; how it is produced, transported and delivered, and what methods of control are adopted to insure its purity. The development of the milk business in the United States within the last 75 years shows progress, and an increased effort on the part of farmers, chemists, railroads, and health officers to cooperate in supplying the community with good milk. This book gives a detailed account of the chemical composition of milk and the stages of bacterial decomposition. Many diseases communicable by milk are enumerated. The various methods of control of tuberculosis are described: control by immunization, by tuberculin testing, or by the Manchester, Osterag, Bang, or Birmingham methods. One chapter is devoted to the dairy cattle and the dairy farmer in America; descriptions are given of various types of cows and barns and various systems of ventilation.

Among other problems with which the book deals are: the problem of sanitary production of milk, the sources of contamination and suggestions for minimizing milk infection; the problem of transportation, its sanitary and economic phases; the milk contractor and his relation to the consumer and the producer; the importance of the North system in the maintenance of country milk plants, and the general features of city milk plants; milk inspection and standardization, pasteurization, sterilization by electricity and ultraviolet rays; and the problems of bottling and distributing milk. The principles of modern milk control, by Federal, State or municipal agencies and by the contractor are discussed. The importance is emphasized of maintaining public interest in the milk supply, for it is chiefly by means of this cooperation that an abundant supply of inspected, pasteurized milk can be furnished to the community.

State Sanitation. By GEORGE CHANDLER WHIPPLE. Cambridge: Harvard University Press. 1917. Volume I.

The object of "State Sanitation" is to describe the past work of the Massachusetts State Board of Health since its establishment in 1869, to bring to life portions of the older reports, and to show how the work of the State Board of Health has fulfilled the ideal set forth in the "Report of the Massachusetts Sanitary Commission of 1850."

Volume I has two parts. The first includes the history of the State Board of Health from the earliest beginnings of public health in Massachusetts—the first quarantine regulations, water supplies, sewers—to the present day. The State Board of Health was organized in 1869; its early work deals with such problems as intoxicating liquor, the control of the business of slaughtering, the sale of poisons, and the effect of improper housing on sickness and death among the poor. In 1879, the existing boards were combined into the State Board of Health, Lunacy, and Charity. Important work was done in 1882 and 1883 in the protection of foods and drugs and in the study of diseases. In 1886, the State Board of Health was again reorganized and numerous engineering enterprises were begun. The book includes detailed information regarding experiments in the antitoxin and vaccine laboratory, the protection of food supply and of the purity of inland waters, the Lawrence Experiment Station and the State House Water and Sewage Laboratories, later engineering work, and the cost and achievements of the State Board of Health.

Part 2 contains the "Report of the Massachusetts Sanitary Commission of 1850." It discusses the sanitary movement abroad and at home, a plan for a sanitary survey of the State and reasons for approving the plan recommended.

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THE WANING INFLUENZA EPIDEMIC.

WITH the bright, clear days of the past week, the influenza-pneumonia epidemic in the Eastern section has shown a gratifying decrease in the number of new cases as well as in the death rate.

But while conditions are improving here, the influenza now has spread to practically every part of the country. Reports to the public health service showed the disease is epidemic in many Western and Pacific coast states as well as in almost all regions east of the Mississippi river.

Its spread also continued in the army camps, the number of new cases reported being greater than on the day before.

Influenza is now epidemic at three places in Arizona, in Maryland, in many parts of Arkansas, in Louisiana, Missouri, Mississippi, Nebraska, North Carolina, North Dakota, Ohio,

South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia and many other states. In Mississippi amusement places over the state have been ordered closed and public gatherings prohibited at Seattle, Bremerton, Pasco, Prosser, Sultan and Port Angeles, Wash.

The disease is reported from many parts of California, while in Texas the malady has been reported from 77 counties, with the number of cases varying from one to 4,000 in each county. A slight decrease is noted in the number of cases reported in Massachusetts, but in the District of Columbia the malady is spreading rapidly, more than 200 new cases being reported.

The epidemic continues in New Jersey and the Public Health Service announced that a physician has been placed in charge at Perth Amboy in coöperation with the State and local health authorities. He had been directed to make the necessary arrangements for giving medical and nursing assistance. Aid was especially needed at this point, it was said, because of the recent explosion, which has increased the danger of the spread of influenza, pneumonia and other communicable diseases.

New cases of influenza reported recently at army camps totalled 13,605, a slight increase over the preceding day. There also was an increase in pneumonia cases, with 2,842 reported. The 820 deaths made a total of 6,543 in the camps since the epidemic started last month.

Camp Funston, Kan., reported 1,430 new influenza cases, while Camp Custer, Mich., reported 1,000, and Camp Taylor, Ky., 607. The highest number of pneumonia cases, 370, was reported at Camp Meade, Md., while Camp Custer had 275 new cases and Camp Grant, Ill., 201.

So great has become the need for nurses and nurses' aids throughout the country that a special appeal for all possible volunteer aid has been issued by Surgeon General Rupert Blue of the United States Public Health Service. Volunteers are urged to register their names, addresses, qualifications for service, and earliest date of availability, at their local Red Cross Chapter or at the Red Cross Headquarters in Washington, D. C.

There is a growing demand for open-air

treatment, according to State Health Commissioner Dr. Eugene R. Kelley, and many applications have been made to the State authorities for assistance. The department has decided, after realizing the success attending the open air treatment applied by Dr. Walter A. Brooks at the Corey Hill, Brookline, camp, to build shacks in Lawrence, Ipswich and Haverhill, and at the Medfield State Asylum for the insane.

A report on the influenza situation in prisons was issued from the State Board of Health Wednesday, October 9. At the Massachusetts State prison, with 554 inmates and 76 officials, there have been 162 cases and two deaths. None of the cases is serious. In the Concord Reformatory, with a population of 520, of whom 365 are inmates, there have been 325 cases and four deaths, which is the largest proportion reported in any institution. At the Sherborn prison for women, with a population of 500, of whom 110 are on the administrative staff, and where there has been quarantine, there have been only three cases and no deaths.

At the institution for the feeble-minded at Waverley, with a population of 560, there were 20 deaths up to Friday.

Early in the week the members of the State Guard began breaking camp at the William A. Brooks Hospital Camp at Corey Hill, Brookline, where, since September 9, more than 300 cases of influenza among the men of the merchant marine fleet have been successfully treated by the open-air method. This colony has numbered as high as 200 tents, and within a day or so the number will be reduced to about 10, where the remaining convalescents will be kept until they have fully recovered and are ready to return to their ships.

Despite the many cases that have been treated there, the number of deaths has been surprisingly small. The open-air treatment, even during a week of severe rain storms almost every day, has proved highly efficacious, and the men have been sent back to their ships with renewed strength, due to the exercises they have undergone during their convalescence.

Arrangements have been made to ship the dismantled tents to other points, where the need of hospital facilities is apparent and calls have been made for open-air hospitals. It is probable these camps will be under the direction of the State Guard members, as was the camp at Brookline.

Boston has persevered in its battle against the gripe and the week has seen the continued closing of theatres, schools, churches, clubs, saloons and other places where public gatherings are wont to be held.

The municipal authorities, acting with Health Commissioner Dr. W. C. Woodward, conferred with the heads of transportation companies, labor organizations and representatives of the retail stores in efforts to relieve the congestion which daily menaces the public health of the thousands who work in the city and who must ride to and from their places of employment.

It was agreed to restrict the hours of business of all retail stores (except grocery stores and shops where food is sold) to the time between 10 a.m. and 6.15 p.m. In connection with the new closing order Dr. Woodward is reported to have said:

"One of the most serious causes of the spread of the present epidemic of grip is the congestion occurring at rush hours in railroad and subway stations, railroad trains, elevated trains and trolley cars.

"Stores and business offices, generally speaking, open about 9 o'clock and close about 5. The result is that between 8 and 9 o'clock in the morning and 5 and 7 o'clock at night there is tremendous congestion on public conveyances and at stations.

"In order to relieve this congestion and spread the traffic over a longer period with less congestion it has been deemed necessary to order retail department, dry goods, specialty, clothing and furniture stores and shops not to open before 10 a.m. and to close at 6.15 p.m. This means that not only should they close at 6.15 p.m., but that they should not close before that time.

"This regulation should bring the congestion caused by shopping at somewhat different hours from the congestion caused by business offices.

"In order to relieve congestion as fully as possible, all business offices within the city are strongly urged and requested to close until further notice at 4 p.m. It has not been thought practicable at present to issue an order to this effect, but if the request is not generally observed, such an order will probably be issued."

The reported death rate from September 14 to October 14 shows the rate of increase and decrease of the epidemic.

	INFLUENZA	PNEUMONIA	TOTAL
Sept. 14	9	12	21
Sept. 15	15	9	24
Sept. 16	23	5	28
Sept. 17	28	13	41
Sept. 18	30	15	45
Sept. 19	32	19	51
Sept. 20	44	10	54
Sept. 21	57	23	80
Sept. 22	44	19	63
Sept. 23	74	13	87
Sept. 24	81	28	109
Sept. 25	81	24	105
Sept. 26	123	33	156
Sept. 27	107	37	144
Sept. 28	128	24	152
Sept. 29	119	30	149
Sept. 30	142	29	171
Oct. 1	152	50	202
Oct. 2	135	40	175
Oct. 3	166	25	191
Oct. 4	154	29	183
Oct. 5	117	32	149
Oct. 6	153	37	190
Oct. 7	146	24	170
Oct. 8	123	27	150
Oct. 9	124	20	144
Oct. 10	86	28	114
Oct. 11	108	18	126
Oct. 12	94	27	121
Oct. 13	72	13	85
Oct. 14	94	25	119
Oct. 15	67	31	98
Oct. 16	57	14	71
Oct. 17	41	12	53
Oct. 18	44	16	60
Totals	3075	800	3875

Quincy has the best report of any city in the State. Only two new cases and two additional deaths have been announced. Conditions are so satisfactory in Quincy that the Maryland State hospital train has left that city for Baltimore.

Brockton also reports that it has influenza under control. Seven deaths and eighty-two cases were listed in the latest report. Brockton was one of the hardest hit cities in New England. It was necessary virtually to quarantine parts of the city when the number of cases had reached the "peak" of the epidemic.

Camp Devens reports a return to virtually normal conditions. For October 14 only three deaths and no new cases were reported. The Liberty Theatre, Y. M. C. A. and K. of C. huts and other recreation centres re-opened Friday evening, and other entertainments have been planned to proceed as usual the coming week.

At present Fall River is one of the hardest hit cities in the State. It reported 688 cases October 14, as against 462 during the preceding 24-hour period. New Bedford and Taunton also are suffering acutely. The tenement houses in the mill cities are regarded as fertile fields

for the spread of the disease. Until this phase of the situation can be handled properly numerous new cases will continue to be recorded.

Lynn states that the situation there is brightening. A home is being established for the care of children whose parents are stricken. In the surrounding towns there are few new cases.

While the situation here in Massachusetts is brightening, reports come from Pennsylvania to the effect that that State is feeling the increase of the influenza to such an extent that it wants to have Massachusetts return the physicians and nurses which it has loaned to us. The nurses were returned October 10 and the physicians were also sent back. One feature of the Pennsylvania report is that the influenza has struck the miners in the coal region, which will have its effect upon the output of coal.

The State Department of Health is sending to the health department of every other State in the Union information about the course followed in Massachusetts, calling attention to the fact that the best treatment seems to be that with tents and with the open-air shacks. Fresh air and sunshine are the most helpful aids which the department has found in the treatment of the influenza and the Massachusetts department desires to help all the other States as much as possible.

REEDUCATION OF BELGIAN WAR CRIPPLES.

THE Red Cross Institute for Crippled and Disabled Men has issued for July 17, 1918, an interesting pamphlet entitled, "Provision for the Reeducation of Belgian War Cripples," by Gladys Gladding Whiteside. It describes methods employed for functional and vocational reeducation, and for the organization of schools and instruction in technical training.

For Belgian war cripples, reeducation is compulsory. In December, 1914, the Hospital Anglo-Belge was opened in Rouen. Later, annexes were organized at Orival and Saint-Aubin les Elbeuf, and in 1916, a new model hospital was built at Bon Secours. At these hospitals, the several curative methods included under the term "physiotherapy" are used. The machines do not allow the patient to remain passive, but are designed to demand active muscular effort. Thermotherapy—including hot air baths, hot water baths, and local air applications—is also made use of. Artificial limbs are made chiefly

by the mutilés themselves. There are two types of legs furnished—a leg of moulded leather similar to French models, and a leg of hollowed wood, called the American type. The dress arm is made of moulded leather with a rigid hand and articulated thumb, which can be exchanged for a hook or ring.

There are two schools for vocational training in Belgium—the “*Foole nationale belge des mutilés de la guerre*,” at Port-Villez, and the “*Dépôt des Invalides*” at Sainte-Adresse. Shops have also been organized in which men are taught to readapt themselves to work. The school at Port-Villez is supported by the Minister of War. One year after its establishment in 1915, 1200 men were being reeducated there. The school is composed of ninety-two wooden barracks of the type of portable field huts, with double walls and cement foundations. In addition, the school is furnished with a large meeting hall, officers’ quarters and an infirmary, a steam sawmill and joinery, garage and repair shops, stables, a poultry yard, and a large garden.

The work of the school is divided among three departments: the medical service, the academic department, and the department of technical training. The medical service provides functional reeducation for those who need it, by such means as exercising apparatus, electricity, heat, massage, curative gymnastics and fencing, games, and sports. This department also observes the effect of work upon physical condition and the influence of handicap upon efficiency. In addition, this division manufactures any special orthopedic or prosthetic appliances needed.

The academic department provides general schooling for men learning trades, theoretical instruction in the trades, and special courses designed for clerks. Men in the trades are divided into three groups—the illiterate, those who have had the rudiments of schooling, and men who have gone through grammar school. The theoretical instruction is the same for all the trades and includes the study of tools and machinery, of raw materials, the processes of the trade, how to determine the sale price of the articles made, and how to place them on sale. In the commercial school, there are four departments: a primary department, a department preparing for civil service positions, a commercial department, and a normal depart-

ment for the training of teachers. The courses are divided into two terms of six months each.

In the department of technical training, over forty trades are taught, the length of the course depending upon the natural aptitude of the men. The shops are operated for production as well as for training, but good teaching is never sacrificed for the sake of increasing production. Machine work in carpentry, hand carpentry and cabinet-making, pattern making for casters, toy-making, wood-carving, wood polishing, oxy-acetylene welding, automobile mechanics, plumbing and zinc-working, clock-making, electricity, shoemaking, tailoring, upholstery, basketry, typesetting, bookbinding, and brushmaking are among the trades taught.

The “*Dépôt des Invalides*” at Sainte-Adresse was founded by M. Schollaert, president of the Belgian House of Representatives, and arrangements were made for providing both functional and vocational reeducation. This school is organized in practically the same way as the one at Port-Villez, with a medical department, an academic department, and a technical department. At the end of 1916, 1699 men were present in the school.

The “home university” of Paris completes the system of vocational instruction organized by the Belgian Government for its disabled soldiers. Here they are boarded and lodged at the expense of the government while they pursue their studies in the great Paris schools.

Series 1, Number 16, issued for July 24, 1918, by the Red Cross Institute for Crippled and Disabled Men, offers a preliminary survey of the opportunities for the employment of disabled men. It describes the processes, working conditions, and advantages and disadvantages for cripples of various industries. National and local trade associations have been visited and trade journals have been asked to publish articles on training and employment. Thus far, 1203 kinds of work possible for leg cripples and 278 kinds for arm cripples have been found. 542 factories have been investigated since January 1, 1918. One of the most interesting results of the work of the survey has been the change in the attitude of the employer, who has now been educated to receive the cripple into industry.

In the piano industry, the processes which have been found to be most possible for cripples include air-brush varnishing, painting and filling, rubbing, doctoring, side gluing, cabinet

making, finishing, tuning, regulating, fine polishing, installation, making, cutting, boring, and wiring hammers, case making, sanding machines, gluing, and stringing. The advantages for cripples in this trade are: trade is not seasonal or dangerous; working conditions are good, and the machinery is not complicated; men can be taken into factories while learning; about one-third of the work, with slight adjustment, could be done by either arm or leg cripples. Disadvantages are: some of the work is heavy; small factories are impossible because each man must do such varied work.

Over fifty per cent. of the work in the leather industry can be done by cripples. Among the processes adaptable to cripples are: lining trays, cutting, riveting, nailing, pasting, mounting locks, coloring, making frames, pasting and stitching, punching, and turning. Wages in this work vary from \$9 to \$30 a week, working conditions are usually good, and the fire risk is not great.

The rubber industry affords many opportunities for disabled men. Processes most suitable include operating power sewing-machines, riveting machines, power cutters, and spreading and milling machines. Seam cementing, mixing rubber, molding valve seats, making belting, sullying vems, and vulcanizing are possible. Beginners receive from \$9 to \$12 a week, and skilled workers from \$30 to \$35. Ventilation and light are usually good, and employers will take men while they are learning. There are two chief disadvantages in this trade: (1) manufacturing mechanical rubber is heavy work for cripples, and (2) the hours are long.

The paper goods industry as a whole trade is an undesirable one for cripples, as the rolls of paper are very heavy and the machines in many branches are high-powered and dangerous. Employers are willing, however, to take crippled men wherever possible.

The shoe industry offers many opportunities, for there are three hundred different processes involved in it. From 50 per cent. to 75 per cent. of the work can be done seated. Possibilities for one-legged men include coloring, sewing machine operating, bench work, repairing, pasting, folding, bottom filling, lasting, cutting, and designing. For one-armed men, there is coloring edges, leather repairing, pasting edges, folding, leveling, bottom filling, last picking, packing, cutting, and designing. Wages vary greatly, from \$10 to \$45; hours are long;

light and ventilation are usually good; most of the machinery is not dangerous.

In the manufacture of sheet metal goods, there are few processes at which a one-armed man could work, but a one-legged man could be adapted to almost all the branches. Work in metal trades is not good for persons suffering from nervous strain, for there is a great deal of noise. It would be harmful, also, to anyone suffering from lung diseases or lung wounds, as there is a great deal of powdered metal in the air.

The silk industry is not recommended for cripples, for it consists chiefly of piece work, which entails haste and strain, and manufacturers object to taking on cripples for the material is very valuable.

The cigar-making trade offers good opportunities for handicapped men, for most of the operations are performed seated. There is not a chance for one-armed men, however, and eyesight must be unimpaired.

The candy industry promises to be a good trade for cripples after the war, for the following reasons: candy per capita is steadily increasing; wherever the sale of liquor is curtailed, the consumption of candy increases from fifteen to fifty per cent.; the chocolate ration of the soldier and sailor will establish a candy habit. Many places could be filled by men crippled in the legs, but none for those with crippled hands.

The celluloid industry is a good trade for cripples. A man without legs should not be in one of these factories on account of the danger of fire. There are, however, opportunities for both one-armed and one-legged men, much of the work is seated, and the work is light and easily learned.

The optical goods industry is a non-seasonal trade, the work is light and could be done by one-legged men, some of it by one-armed men. Wages are high, and a man could learn a good deal in six months. The principal drawback to placing cripples in this trade is that there are few large factories. Much of the work is standing, but it requires very little strength.

There are opportunities for men in every branch of the motion picture industry. Men with lung wounds or diseases ought not to be in small theatres because of the bad air, and many positions involve considerable eye strain. The industry is growing rapidly, and salaries are exceptionally high.

MEDICAL NOTES.

MEDICAL HISTORY OF THE WAR.—"Colonel Champe C. McCulloch, Jr., M.C., U.S.A., Executive Officer of the Board for Collecting and Preparing Material for a Medical and Surgical History of American Participation in the European War, has arrived in France, to establish his administration for this purpose. During his absence, Lieut. Colonel Casey A. Wood, M.C., U.S.A., will be in charge of this work in the Surgeon General's Office."

A MEDIAEVAL MEDICAL AUTHOR.—In a recent issue of *The Lancet* appears the following item about a mediaeval medical author.

"John of Burgundy," surnamed, "A la Barbe," was a professor of medicine and a practitioner at Liège, and also the author of some medical books. Two treatises written by him in the latter part of the fourteenth century are mentioned. The first upon the plague and the second, in point of time of composition, upon the Corruption of Air as Cause of the Plague. The French originals are apparently lost, but a learned Jew, Benjamin C. Isaac of Carcassone, rendered the last treatise in Hebrew, and a copy of his work may be perused in Manuscript Bibliothèque Nationale, Paris, fonds Hebreu, No. 1191.

The other book may have been one in the library of Charles V. entitled "Le Traité que les Maistres de Medicare les Astronomies de Paris firent de la Pestelence, que fsiique appelle Epydimme en l'An de N. S. 1368." The work translated by Benjamin was dated 1363 and translated about A.D. 1370. In it John of Burgundy speaks of his earlier book, which he says he wrote after the ravages of the plague.

APPOINTMENT OF DR. SWIFT.—Walter B. Swift, A.B., S.B., M.D., of Boston, has just been appointed Consultation Expert for Speech Defects to the Division of Medical Inspection of the Public Schools of Cleveland, Ohio. He is engaged in installing methods in speech correction by directing some 15 teachers to conduct speech correction classes. These teachers he trained last summer to do this work.

LONDON DEATH RATES IN AUGUST.—Statistics recently published show that the total death-

rate of London in August, 1918, was only 10.1 per 1000 inhabitants living. Among the several districts and boroughs the highest rate was 12.5 in Finsbury, a central slum, and the lowest was 5.7 in the city precincts.

RAILROADS ARE REQUESTED TO CEASE RIVER POLLUTION.—The Merchants' Association has long been interested in protecting water supplies and water courses adjacent to railroad rights of way from contamination, and it has urged the installation of suitable sanitary devices.

The matter has been agitated by the Association through the Committee on Pollution and Sewerage, of which Mr. Edward Hatch, Jr., is Chairman, and has been brought to the special attention of the BOSTON MEDICAL AND SURGICAL JOURNAL by Mr. Hatch. The matter has been taken up with Director General McAdoo in a letter delivered to the Secretary in person. It follows in part: "We beg to ask your earnest and immediate consideration of a plan to provide the Pullman cars, passenger coaches, mail cars and railroad workmen's conveyances with sanitary devices to prevent the discharge of the contents of the toilets used on the trains upon the railroad thoroughfares of this country. The present method scatters the objectionable and dangerous material on and along the roadbed. As the railroad lines usually follow the course of a river or some other body of water, it becomes evident that there is great danger of pollution from the railroad. The material that is not thrown directly into the water, may be washed therein by rains, or blown in by the wind, or it may be fanned into mechanical suspension by the motion of the train and in this way enter the car windows, ventilators, dining cars and station dining-room or nearby houses, scattering broadcast the infected particles containing typhoid, tuberculosis and influenza bacteria. Also the bodies and clothes of the passengers are covered with dust and conveyed to the home, and the flies are important factors in the spreading of diseases.

In 1912 a bill was introduced in the New York Legislature to compel railroads traversing the State of New York to provide for the protection of the public health by prohibiting

the present form of water-closets on railroad trains. As most railroad vehicles are interstate carriers, it was deemed necessary to take legislative action by each individual state, and the coöperation of the respective governors sought with indifferent success, due probably to interstate complications.

Under your jurisdiction as Director General of the Railroads of the United States, the interstate boundaries, as related to railroads, are practically obliterated, and we believe under Federal control this reform on behalf of the public health could be instituted with few complications and little annoyance."

We are glad to ask the coöperation of all earnest, public-spirited citizens in this matter of such a fundamental and vital importance to the well-being of the people.

WAR NOTES.

APPOINTMENT OF GENERAL IRELAND.—Major General Merritte W. Ireland, U. S. Army Medical Corps, at present medical chief of staff with the American Expeditionary Force, has been nominated by President Wilson to be surgeon-general of the army for the period of four years beginning October 4, 1918, vice Major-General William C. Gorgas retired on October 5, on account of age.

Surgeon-General Gorgas is in Europe now with Secretary Baker, and it is reported that he will remain there as the medical representative of the United States army at the inter-allied war council.

General Gorgas, having earned a world-wide reputation as sanitarian when the Panama Canal zone was swept clear of the yellow fever and other plagues, will probably have a similar task in cleaning up the territory now being recaptured from the enemy.

Major General Noble will succeed to General Ireland's post in Europe.

Other nominations for temporary promotions included: Brigadiers general medical corps: Cols. James D. Glennan, John M. T. Finney, William S. Thayer.

Medical Directors Robert H. Kennedy and Albert N. D. McCormick of the Navy were nominated to the rank of rear admiral for temporary service.

PLANS FOR RECONSTRUCTION HOSPITALS.—Plans have been completed for the physical re-

construction of disabled soldiers in the general military hospitals. These plans are formulated with a view to close coöperation with the war department committee on education and special service in the work of restoring men to full or limited service.

The task of fitting men for service is at present the most pressing need. When play and work and study will help a man to get well, this kind of medicine will be prescribed.

Surgeon-General Gorgas has designated the following general military hospitals for the work of reconstruction:

Walter Reed General Hospital, Washington, D.C.; General Hospital No. 2, Fort McHenry, Md.; General Hospital No. 3, Colonia, N. J.; General Hospital, No. 6, Fort McPherson, Ga.; General Hospital, No. 7, Roland Park, Baltimore (for the blind); General Hospital, No. 8, Otisville, N. Y.; General Hospital, No. 4, Fort Porter, N. Y.; General Hospital, No. 9, Lakewood, N. J.; General Hospital, No. 11, Cape May, N. J.; General Hospital, No. 16, New Haven, Ct.; General Hospital, No. 17, Markleton, Pa.; Lettermann General Hospital, San Francisco, Cal.; United States Army Hospital, Fort Des Moines, Ia.; Plattsburg Hospital, Plattsburg, N. Y.; and General Hospital, Fort Bayard, N. M.

The policy of the hospitals is that no man shall be discharged until he has gained complete recovery, both physical and mental. Not only will the ordinary means employed in medicine and surgery be used, but also physical measures such as are employed under physiotherapy, active exercises, indoor and outdoor games. It is hoped that by these means the men will be restored to their maximum efficiency.

MAKING SURVEY OF NURSES.—According to an announcement made recently by the American Red Cross War Council, the American Red Cross is now making a nation wide survey of the country's nursing resources, the work in all the territories and insular possessions being done by women of the Fourteenth Division of the American Red Cross.

The survey, being made at the request of Secretary Baker and Surgeon-General Gorgas of the Army, is for the purpose of getting information regarding the number of nurses available for war service, without endangering

civilian needs. The necessity for such a survey is emphasized by the fact that in many communities there has been a great scarcity of nurses during the epidemic of Spanish influenza.

The survey is to include every class of nurse, as well as midwives and trained attendants, practical nurses, women who have taken American Red Cross nursing courses and also women of the foreign-speaking population who have had nursing experience. The necessary questionnaires are being distributed by American Red Cross workers.

L. A. FROTHINGHAM TELLS OF BASE HOSPITAL NO. 6 IN FRANCE.—Louis A. Frothingham, former lieutenant governor and a member of Gov. McCall's commission which went to France recently to investigate conditions among Massachusetts troops, spoke at Trinity Church about the conditions and location of Base Hospital No. 6 or the Massachusetts General Hospital Unit.

"Dr. O'Neil of the hospital," said he, "came aboard our boat early in the morning, told us where the hospital was and asked us if we would visit it that afternoon. We went in a taxicab. It is located some miles from a large city in a country where once the people were forced to walk on stilts to care for their stock or do farming work. The country reminded me of our own Cape Cod.

"On one part of the grounds, in which the hospital is located, stands a large chateau where the officers sleep and have their mess. The main hospital is about a quarter of a mile from it. At one time the main hospital was a French boarding school. The French government took it over for hospital purposes.

"When we arrived there were more buildings being erected with concrete floors and other sanitary features. The equipment which the unit took away with them has served to make them much more efficient and independent. There is nobody at the hospital who is doing a finer work than Chaplain Sherrill. He is the postmaster, the censor, letter writer and chaplain all in one. The hospital is conducted along strict military lines and we found no better organization during our travels.

"When we first visited it there were but few patients, but when we returned, three or four weeks later, the wounded were arriving fast.

It is located two days away from Somme and the fact that wounded were transferred so far speaks well of the regard the high commands held for the institution. The further fact that from time to time surgeons and men are called from it to the front to organize hospitals is a tribute to the efficiency of the organization. The hospital is a monument now, and will remain so to Massachusetts and the United States of America."

BOSTON AND MASSACHUSETTS.

WEEK'S DEATH RATE IN BOSTON.—During the week ending Oct. 12, 1918, the number of deaths reported was 1285, against 231 last year, with a rate of 85.43, against 15.59 last year. There were 101 deaths under one year of age, against 26 last year.

The number of cases of principal reportable diseases were: diphtheria, 44; scarlet fever, 9; measles, 3; whooping cough, 19; typhoid fever, 2; tuberculosis, 32.

Included in the above were the following cases of non-residents: diphtheria, 10; measles, one.

Total deaths from these diseases were: diphtheria, 5; whooping cough, 10; typhoid fever, 1; tuberculosis, 25.

Included in the above were the following non-residents: diphtheria, 2; tuberculosis, 1.

Influenza cases, 1520; influenza deaths, 850. Total deaths for week, 1285.

REMOVAL OF FISK HOSPITAL.—On October 14, 1918, the Fisk Hospital was moved to 5 Sparhawk St., Brighton District. The estate of Dr. Horace E. Marion, which is admirably adapted for this work, has been purchased.

HOSPITAL BEQUESTS.—The will of the late Frank E. Peabody of Boston whose real and personal property amounted to about \$2,500,000 gave \$10,000 to the Massachusetts General Hospital for the maintenance of free beds.

The will of the late Jason S. Bailey of Boston provides that almost his entire estate shall eventually go to public institutions. The Boston Nursery for Blind Babies is to receive \$1000, and one-fourth of the residuary income is bequeathed to the Children's Hospital.

APPOINTMENT OF DR. KAZANJIAN.—Dr. Varaztad H. Kazanjian of the first Harvard

Medical Unit that went to France, has been appointed Professor of Military Oral Surgery at the Harvard Dental School.

BRIGHTON OFFERS SEMINARY FOR HOSPITAL.—The Emergency Public Health Committee has accepted Cardinal O'Connell's offer of St. John's Seminary in Brighton and established a convalescent hospital for male patients there. Dr. Wm. H. Devine, ex-surgeon General of Massachusetts and now head of the Medical Department of Boston's Public Schools, has consented to become administrator of the new hospital. Patients have been received from the Massachusetts General Hospital, Carney Hospital, the Merrill School, Cambridge, the Homeopathic Hospital, and the Peter Bent Brigham Hospital.

The hospital has not only an ideal location for a convalescent home, but also ideal construction with its light and airy rooms, large corridors and fine kitchen facilities, all of which will insure a quick and better recovery for the sick.

There is enough accommodation for 100 patients. Up to Oct. 9, 30 patients were receiving treatment; thirty seminary theologians are acting as hospital orderlies and 17 public school nurses are aiding Supt. Devine and his staff of seven physicians.

The physicians assisting Dr. Devine are Dr. John Bossidy, resident physician; Dr. Joseph Cogan, Dr. Thomas Broderick of Jamaica Plain; Dr. Irving Sobotky of Boston; Dr. W. H. Robinson of Boston, and Dr. Solomon Rubin of Boston.

NOTES ON THE INFLUENZA EPIDEMIC.

Plymouth County reports made by various boards of health show that the influenza-pneumonia epidemic is on the wane in this locality. The Rockland health authorities reported only 23 new cases on October 6th, as compared with 30 two days previous. The number of new cases has decreased one-half. Dr. Smith sent here by the State Board of Health to supervise the anti-epidemic campaign, received word to report at once to Fort Oglethorpe, Ga., for service in the medical corps. There were no deaths in Bridgewater recently and a decrease in the number of cases was reported.

Newport, R. I., reports that the influenza situation both in this city and in the 2nd naval

district was more encouraging. In the city there were only two deaths with fewer new cases. There were two deaths in the naval district with but 16 new cases. Fort Adams reported one death, with no new cases.

At Camp Devens there were five deaths on October 7, four pneumonia cases and 22 of influenza. Relatives of the soldiers seriously ill remaining at camp dropped to 35 at the K. of C. building and 31 at the Hostess House.

Fitchburg has closed all public places in order to diminish the number of new cases. The Associated Charities and the Visiting Nurses' Association, with prominent women, are assisting in caring for the sick. Canteens have been established to prepare nourishment for the sick and children whose mothers have been stricken with the disease. Through Dr. Francis A. Finnegan of the State Board of Health, three more nurses came to Fitchburg recently to assist in the care of the sick. Undertakers are unable to provide caskets, and special arrangements are being made at Fitchburg for their manufacture. Two emergency hospitals are filled and lately a refugee home for children was established in the old Cross mansion. It is equipped with 25 or more cots and blankets supplied by Camp Devens and is under the supervision of the Red Cross. October 12th reports from Fitchburg showed that the epidemic had broken out anew and that there were 15 deaths and 153 new cases in 24 hours.

Taunton reports a slight decrease in the number of new cases. At the Morton Hospital 30 cases are under treatment and there are 40 cases at the Emergency Hospital in the Broadway Congregational church. There is a great demand for volunteer workers. At the newly opened convalescent hospital, there are 11 cases. Volunteer workers have attended 50 cases and supplied 23 families with food.

In Fall River, more than 1,000 new cases of influenza have been reported since October 5. There have been 48 deaths.

Five deaths were reported in Chelsea, bringing the total death record from influenza up to 100, excluding deaths at the Naval and Marine Hospitals. The number of new cases showed a marked decrease.

At Ipswich there has been installed a 50-tent unit for the care of influenza and pneumonia cases at Cable Hospital, under the direction

of the Federal Government. It will be in charge of an army officer, with the medical supervision directed by the local Board of Health. There is a falling off of new cases in this vicinity.

In Brockton 51 deaths were reported on October 7, more than double the total of any previous two-day period. In a public statement the Board of Health declared that while the epidemic is not yet under control, it believes that there will be an improvement in the condition.

In Newburyport there were eight deaths from influenza and pneumonia on October 6, but the Board of Health declares that the general situation is improving. A diet kitchen has been opened at the Purchase Street school-house.

In Quincy the crisis is past, but the ban on all public meetings is still maintained. The three emergency hospitals had no deaths on October 8 and 15 patients were discharged from the hospital. The Maryland State Hospital train may leave Quincy for Maryland, where its services are needed. On October 7 there were three deaths at the Chubbuck Street Emergency Hospital and two in homes. There were only 57 patients in the latter hospital as compared with 180 when the epidemic was at its height.

Milford influenza conditions are getting decidedly better. There were only three new deaths, a third as many as the number contained in the previous report. Milford's total is now 80, and the high-water mark is believed to have been reached.

The Westfield State Guard went on patrol duty in different sections of the town on October 11, as a means of preventing further spread of the influenza. An increase in the number of cases was reported on October 11, making a total of 70 cases. The epidemic is at its height here and no relief is in sight. The Noble Hospital is crowded beyond capacity.

Worcester has 327 new cases and has been ordered to close all public places until further notice. According to reports, 1,196 cases have been reported since October 4. The great number of burials have caused the grave-diggers to announce that there will be no further funerals in the Swedish cemetery until the funerals already arranged for have been taken care of. The Street Railways Company has been seriously handicapped. Dr. Wm. C. Roland of

Indianapolis has been assigned to Worcester and will serve as night physician at the emergency hospital established on the fair grounds at Greendale. There are nearly 50 patients here. Owing to the epidemic, the Worcester County Teachers' Convention has been called off. October 10 reports show that the epidemic is under control.

In Attleboro there were 19 new cases on October 11 and four deaths from influenza. In North Attleboro the influenza seems to have been checked. The few cases reported in the last 24 hours seem to be of a mild nature.

In Lawrence, the influenza situation has improved decidedly during the last 24 hours, making the lowest number of cases reported since two weeks. On October 11 seven died from influenza and 18 from pneumonia. The military emergency hospital on Emery Hill, built to accommodate influenza and pneumonia patients, will probably serve as a receiving base for Methuen, Andover and North Andover cases also. About 200 more cots have been added to the equipment at the hospital. There were about 150 patients in the hospital Oct. 12. About 70 boys from the Essex County Training School were added to the hospital. On October 6 about 40 cases were reported by physicians and 223 cases yesterday. On October 7 11 deaths were reported and two from pneumonia.

The epidemic seems to have fallen off at Lynn, Swampscott, Marblehead, Nahant and other surrounding towns.

The Salvation Army is taking an active part in the local campaign. Already 350 cases have been turned over to visiting nurses of that organization by 11 doctors of the S. A. Dispensary. The Army has two corps of nurses working in the North, South and West Ends. Colonel Gifford of People's Palace, who has charge of the corps, asks donations of various kinds for the comfort of the sick.

Springfield has cancelled the State Conference of Charities to take place on October 30, on account of the epidemic.

Conditions in Athol seem slightly better. There are now seven patients in the Crescent Street Hospital. Three deaths and 15 new cases were reported on October 6, making a total of 730 cases. Eight patients were sent to the Emergency Hospital, making a total of 13 there. All public soda fountains and public meeting places were closed.

The epidemic has spread over South Africa. There were 140 burials in Maitland cemetery, 100 new cases in Johannesburg and 11 deaths there on October 6. In the mining districts the spread of the epidemic has been reduced through the agency of the hospitals from 30,000 to 20,000. Thousands of volunteers are assisting and thousands have been inoculated.

Henry B. Endicott has asked for more tents for use during the epidemic. The ambulances of Ambulance Co. No. 1 and the 1st Motor Hospital Unit have been distributed as follows: Corey Hill, 3; Brookline, 3; Gloucester, Lawrence, New Bedford, Brockton, Boston Fore River Shipbuilding Yards, 1st Naval District and Northeastern Army Department, 2 each. Lieut. Joshua B. Holden, who has had charge of the ambulances, has been on duty day and night since the epidemic started.

Selected members of the dental profession are organizing to combat the epidemic, by offering their services in connection with vaccine inoculation. Because the medical profession is so overworked, the dentists have offered their assistance. Dentists appointed under the Dental Hygiene Council are now working in connection with Dr. Leary's laboratory at Tufts Medical School, doing nearly all the inoculation and assisting in the preparation of the vaccine.

Camp Dix shows a decrease in the number of cases. Twenty-eight men succumbed and 85 new cases of pneumonia and 76 cases of influenza were reported. The total number is now 2,907 influenza cases and 1,151 pneumonia cases.

Durham, N. H., is taking all precautions to safeguard the public. Very few cases are in evidence now and classes in colleges and schools will be held outdoors wherever possible.

Manchester, N. H., reports that the situation remains about the same. The hospitals remain overcrowded and the ambulance service is in constant use.

Portsmouth, N. H., appropriates \$2,000 to fight the epidemic. There was no abatement in the number of deaths, 10 being reported in the Portsmouth zone and three in the Naval Hospital.

Nashua, N. H., reports seven deaths on October 8, making a total of 102. The total number is an increase over the previous day.

Major John Buckley, head of the Selective

Service Administration in Connecticut, has telegraphed the War Department that Dr. John T. Black, State Health Commissioner, has recommended that physical examinations of draftees be postponed for 10 days. The influenza has occupied the doctors to the exclusion of everything else. On October 5, 18 deaths occurred and new cases are being reported hourly.

The Connecticut valley shows improvement on the whole in the influenza situation. In Springfield, on October 11, 59 new cases and one death were reported, a somewhat smaller number than usual. A slow but steady decrease in the rate is apparent.

Manchester, N. H., has ordered the closing of all factories in the hope of stamping out the influenza. More than 5,000 employees of various establishments are sick.

While a continued decrease in the number of new cases of influenza in the army camps has been noted, the spread of the disease among the civilian population is still far from being checked in the City of Washington, on October 8th reports. Eleven thousand, seven hundred and fifty cases have been reported by all army camps as a total number of new cases, making a decrease. Camp Taylor, Ky., reported the largest number of cases, 1,044. Camp Funston, Kan., reported 927, and Camp Dodge, Ia., 996. Pneumonia showed the greatest increase at Camp Meade, Md., where 255 cases were reported. There were only 231 new cases at Camp Grant, Ill., and 160 at Camp Sherman, O. Camp Devens has a decrease, Camp Dix showed improvement, with only 29 pneumonia cases and 11 influenza cases. The total number of cases reported from all camps since the disease became epidemic last month now is placed at more than 182,000, while pneumonia cases total 19,283, and deaths 5,671. October 11th reports are not so favorable in Washington. There has been a decided increase in fatalities in the camps, making an increase of 128 per cent. during the last week. Washington civilian population is also greatly endangered, and an effort is being made by the Health Department of Washington to keep out civilian war workers as an aid in checking the epidemic.

The Clinical Congress of the American College of Surgeons, which was to have had its

meetings on October 20, in New York, has been abandoned on account of the epidemic.

Albany, N. Y., has closed all schools, theatres and public meeting places to stop the spread of the epidemic.

In New York City, on October 6, 2,073 cases of influenza were reported as against 2,067 the day before. There were 185 pneumonia cases and deaths from both diseases totalled 113. On Oct. 8 there were reported from this city 588 deaths out of 14,782 cases since September 18. There were 1,500 among the sailors. Dr. Copeland estimated that there are now about 8,000 in the city. A drastic measure, making it a misdemeanor to cough or sneeze in public, has been passed by the New York Board of Health. Penalty, \$500 or imprisonment.

Camp Upton, N. Y., on October 8, showed nine deaths, 127 new influenza cases and 44 new pneumonia cases.

At Annapolis Naval Academy there were two deaths and 50 cases of pneumonia. It is reported to be spreading here.

In Newport, R. I., there were, on October 7, 11 new cases and four deaths among the sailors of the 2nd Naval District, and two deaths among the civilian population. On October 9 there were 17 new cases in the 2nd Naval District. The epidemic seems to be subsiding. The Emergency Hospital has been closed because the epidemic has subsided to such an extent as to eliminate the institution from service.

Providence has 5,000 cases. The hospitals are crowded and churches have abandoned their services temporarily.

At Waltham the Storer-Paine Emergency Hospital has been opened to receive influenza patients.

Colonel Charles Hagadorn forbade publishing the names of influenza victims at Camp Grant. The death toll was 525 on October 7.

At Syracuse the epidemic is decreasing. There are about 10,000 cases in the city.

Camp Custer reports 60 deaths on October 11.

Kansas reports 1,103 cases of influenza in Topeka and a general spreading of the influenza throughout the State. Sixty counties have closing orders against public gatherings.

TRUESDALE HOSPITAL.—Dr. Ester M. Sundelof, roentgenologist at the Truesdale Hospital and

Clinic, Fall River, Mass., has returned to her work at Fall River after a summer spent as house officer and roentgenologist at St. Anthony's Hospital, one of Dr. Wilfred T. Grenfell's mission hospitals on the Labrador coast. Dr. Sundelof is substituting for Captain John H. Lindsey at the Truesdale Hospital and Clinic while he is in France.

The Massachusetts Medical Society.

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1918-1919.

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ESSEX NORTH.—The quarterly meeting of the Essex North District Medical Society was held September 25 at Amesbury Club, where dinner was served. Two interesting papers were read. The first, by Lieutenant Colonel Fred B. Lund, M.D., of the Medical Corps, U.

S. A., of Boston, considered "The Present Needs of Our Country for Physicians;" the second, by Lieutenant Colonel Channing Frothingham, M.D., of the Medical Corps, U. S. A., of Boston, commanding officer of the base hospital at Camp Devens, Massachusetts, discussed "The Clinical Advantages of an Army Medical Officer."

The Censors will meet at Hotel Bartlett, Thursday, November 7, to examine candidates for fellowship.

S. FORREST BURNHAM, *Secretary.*

Obituary.

WILLIAM REGINALD CHIPMAN, M.D.

WILLIAM REGINALD CHIPMAN, M.D., died at his home in Chelsea, October 7, 1918, of heart disease.

Dr. Chipman was born in Kings County, Nova Scotia, May 30, 1849, took an A.B. from Kings College, N. S., in 1888, and an M.D. from Harvard Medical School in 1876. Then he went abroad and studied at the University of Geneva and at the Soho Hospital, London. On his return, he settled in Chelsea, when he engaged in general practice. He was a founder of the Tufts College Medical School, and was the first professor of surgery at that institution; later he held the same chair in the College of Physicians and Surgeons. He was on the staff of the Frost Hospital. A prominent Episcopalian, he was senior warden of St. Luke's church. He married Annie Stockwell Raddin, and had one son, Dr. Fred S. Raddin of Chelsea. His wife dying, he married Ella Stewart. She survives him. Dr. Chipman became a retired Fellow of the Massachusetts Medical Society in 1915.

ARMY AND NAVY MEDICAL CORPS.—Applicants for the Medical Corps of the Army should make application either to Capt. John T. Bottomley, 165 Beacon Street, Boston, or to Capt. Philip Kilroy, 61 Chestnut Street, Springfield. The examiners have application blanks, and will communicate all details as to membership in the Corps. Applicants for the Medical Corps of the Navy should apply to Capt. John M. Edgar, Naval Aid Department, Little Building, 80 Boylston Street, Boston. Captain Edgar has the application blanks, and will give full information as to the requirements and the physical examination.

Miscellany.**MASSACHUSETTS STATE COMMITTEE,
COUNCIL OF NATIONAL DEFENSE,
MEDICAL SECTION.****J. B. BLAKE, M.D.,** *Chairman.***W. L. BURRAGE, M.D.,** *Secretary and Treasurer.*

In response to the postal card request for funds from physicians in Massachusetts who are not in the Government Service, the Massachusetts State Committee, Council of National Defense, Medical Section, hereby acknowledges additional subscriptions from the following physicians through October 7. The funds are for printing, postage, rent of typewriter and extra clerical assistance.

WALTER L. BURRAGE, M.D., *Treasurer.*

October 8, 1918.

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Forrest L. Leland, South Hadley Falls.
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George H. Monks, Boston.
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Hugh Williams, Boston.
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Florence N. Robinson, Lawrence.
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James H. Stevens, Boston.
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F. L. McIntosh, Newton.
Edward J. Denning, South Boston.
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VALUE OF INFLUENZA VACCINE.

FOLLOWING are copies of the official report made to Commissioner E. R. Kelley by the special committees which investigated the value of influenza vaccine as a preventive agent and as a treatment of this disease:

Dr. Eugene R. Kelley,
Commissioner of Health,
State House, Boston, Mass.

Sir:—

We beg to submit the following recommendations:

That the State encourage the distribution of influenza vaccine intended for prophylactic use, but in such manner as will secure scientific evidence of the possible value of the agent. The use of such vaccine is to be regarded as experimental.

That the State shall neither furnish nor endorse any vaccine at present in use for the treatment of influenza.

M. J. ROSENAU, *Chairman*,
G. W. MCCOY,
FREDERICK F. GAY,
Board of Scientific Investigation.
GEORGE C. WHIPPLE, *Chairman*,
WILLIAM H. DAVIS,
F. C. CRUM,
Board of Statistical Investigation.

October 7, 1918.

Dr. Eugene R. Kelley,
Commissioner of Health,
State Department of Health,
State House, Boston, Mass.

Sir:—

The Special Board for Scientific Investigation, appointed to consider the evidence available on the prophylactic and therapeutic use of vaccine against influenza, have reached the following conclusions:

1. The evidence at hand affords no trustworthy basis for regarding prophylactic vaccination against influenza as of value in preventing the spread of the disease, or of reducing its severity. The evidence from the present epidemic, though meagre, suggests that the incidence of the disease among the vaccinated is smaller than among the non-vaccinated. The Board, therefore, concludes that further experimental evidence should be collected.

2. The evidence at hand convinces the Board that the vaccines we have considered have no specific value in the treatment of influenza.

3. There is evidence that no unfavorable results have followed the use of the vaccines.

(Signed)

M. J. ROSENAU, *Chairman*.
FREDERICK F. GAY.
GEORGE W. MCCOY.

October 7, 1918.

Dr. Eugene R. Kelley,
State Commissioner of Health,
Boston, Mass.

Sir:—

The following conclusions have been reached by the Special Board of Statistical Investigation:

1. The weight of such statistical evidence as we have been able to accumulate indicates that the use of the influenza vaccine which we have investigated is without therapeutic benefit. Exceptional cases where apparent benefit has resulted from the use of the vaccine can be matched by other cases where similar recoveries have been made without vaccination.

2. The statistical evidence, as far as it goes, indicates a probability that the use of this influenza vaccine has some prophylactic value.

3. There is also some evidence to the effect that other methods of protection, such as open-air treatment and the use of proper masks, are effective in protecting exposed attendants and the use of vaccine should not be taken as an excuse for omitting such safeguards.

(Signed)

GEORGE C. WHIPPLE, *Chairman*.
WILLIAM H. DAVIS.
F. C. CRUM.

October 7, 1918.

Correspondence.

DRUG REGULATIONS.

New York, Sept. 25, 1918.

Mr. Editor:

In connection with the proposed legislation now before Congress, relating to the Harrison Drug Law which has been proved unconstitutional before the courts in some respects, I would like to ask your attention to the enclosed article on the subject of drug laws and the drug situation in New York State—the birthplace of this "movement." In this State a few medical men, on their own initiative and without support from the organized medical bodies or influential medical men, have fought these drug laws from the beginning. They are now, thanks to the courtesy of the lay press, which has given them a hearing, beginning to make their influence felt in matters of legislation of this character by their education of the public.

I also desire your attention to this matter in view of the recent decision of the Massachusetts courts in the case of *The Commonwealth vs. Noble* (May, 1918, N. E. 510), which is of supreme importance to medical men. It has long been an admitted fact that "justice" is not to be looked for under the regular processes of the law, the best that can be expected of its

machinery are decisions founded upon precedent—of which, in this case, there was none. In convicting a physician for giving a habitual user of morphine a prescription to procure his drug at a price of \$2.00, there should have been taken into consideration his moderation in charging so little for "pandering" to what is adjudicated, in Massachusetts, a "vice." In New York we passed a law compelling the Department of Health to permit morphine to addicts when necessary to save them from the unspeakable degradation which some of them testified before the Legislature they were compelled to undergo in the slums to obtain the drug. At the hearing there were present some of the judges who had passed sentence upon several of these addicts in the criminal courts.

At the meeting in Washington two years ago of the National Drug Manufacturers' Association, an Assistant District Attorney of Boston told how he succeeded in rounding up the druggists and doctors in his city by methods of procedure which he admitted were illegal and unlawful and which he would not have dared to use in the case of habitual criminals aware, as they are, of their legal rights. This violation of his oath of office he excused on the ground of its ultimate benefit to the drug users whom he "cured" by sending them to a corrective State institution officered by political appointees like himself. All this redounded to his credit politically and sociologically—which, in some localities, are now interchangeable terms.

JOHN P. DAVIN, M.D.

SOCIETY NOTICES.

BOSTON SOCIETY OF PSYCHIATRY AND NEUROLOGY.—To accord with the request of the health authorities, the October meeting of the Society will not be held.

DONALD GREGG, *Secretary*.

SUFFOLK DISTRICT MEDICAL SOCIETY AND BOSTON MEDICAL LIBRARY.—It has been decided, because of war time conditions, that during 1918-1919 there will be five meetings of the Suffolk District Medical Society and the Boston Medical Library, instead of seven as in preceding years.

Members are cordially invited to attend these meetings, which will be held at the Boston Medical Library, 8 The Fenway, at 8.15 P.M., on the dates given below.

It will be impossible to announce the subjects and speakers until shortly before the meetings. It is hoped that members will reserve these dates and attend these meetings.

October 30, 1918.—Stated meeting of the Suffolk Medical Society. Speaker: Dr. William C. Woodward, Boston Health Commissioner. Subject: "The Present Epidemic of Influenza." Discussion opened by Dr. Eugene R. Kelley, Massachusetts Commissioner of Health.

December 4, 1918.—Meeting of the Boston Medical Library.

January 15, 1919.—Meeting of the Medical Section, Suffolk District Medical Society.

March 5, 1919.—Meeting of the Surgical Section, Suffolk District Medical Society.

April 30, 1919.—Annual meeting of the Suffolk District Medical Society.

JOHN RAPPT BLAKE, *President*, and GEORGE R. MINOT, 188 Marlborough Street, *Secretary*, Suffolk District Medical Society.

GEORGE W. W. BREWSTER, *Chairman*, and WYMAN WHITTEMORE, *Secretary*, Surgical Section.

EDWIN A. LOCKE, *Chairman*, and GEORGE R. MINOT, *Secretary*, Medical Section.

WILLIAM E. LADD, *Chairman*, Committee on Medical and Social Meetings, Boston Medical Library.

NORFOLK DISTRICT MEDICAL SOCIETY.—A stated meeting of the Society will be held at the Children's Hospital, Longwood Avenue, October 23, at 4.00 P.M. Phone, Brookline 5390.

Communications: Clinical Demonstrations.
Discussion of Matters of General Interest, by the Staff.

The Censors meet for the examination of candidates, Thursday, Nov. 7, 1918.

BRADFORD KENT, M.D., *Secretary*.

RECENT DEATHS.

CAPT. WALTER GRANDAGE, dental surgeon of the 73rd Infantry, died recently at Littleton, Mass. He was a resident of Peabody.

DR. JOHN PERKINS, son of John T. Perkins, of Greenwich, Conn., died in the Presbyterian Hospital in New York on October 10, 1918, after contracting the disease while attending patients ill with influenza.

DR. CLARENCE FAHNESTOCK of New York, Major of the U. S. A., commanding the First Battalion of the 301st Infantry, died while in service in France. He was a graduate of Harvard in the Class of 1898, and was stationed for a time at Camp Devens.

DR. RALPH A. PARKER of Greene, Me., died at his home, on October 14, of heart disease. He was born in Greene 57 years ago and was graduated at Bates College in 1888, and from the Maine Medical School at Brunswick in 1904. He was a member of the Masons and the Grange.

DR. JOHN JOSEPH HASSETT, a Fellow of the Massachusetts Medical Society, died at his home in Lee, Oct. 11, 1918, aged 66. He was born in Stafford Springs and educated in Monson and at the University of the City of New York, where he took his M.D. in 1887. In that year he married Catherine Brennan of Monson. She and two daughters survive him.

DR. WILLIAM R. CHIPMAN, one of the founders of Tufts College Medical School, died at his home in Chelsea, Mass., of heart disease. He was born in Cornwallis, N. B., 69 years ago. He was graduated from King's College Medical School, Winsor, N. S., and from Harvard Medical School. He studied also at Guy's Hospital, London, and at the University of Geneva.

DR. CLARENCE C. DAY died at his home in Newburyport, of pneumonia following an attack of influenza. He was born at Newton, N. H., and was graduated from Dartmouth Medical School in 1891, and, after practicing a year at Newton, N. H., came to Newburyport. He was one of the medical staff of the Anna Jacques Hospital, and a member of the Massachusetts Medical Society, Essex North Medical Society and the Newburyport Medical Club.

DR. EDWARD H. WISWALL of Wellesley, Mass., a specialist on nervous diseases, died recently at the sanitarium on Grove Street, Wellesley, which he had conducted for many years. He was born in Boston, Dec. 21, 1862, and later attended Oberlin College, Harvard Medical School and Boston University Medical School, having been graduated from the last-named institution in 1887. For five years after completing his college education, he was an assistant at the Westborough State Hospital. Returning from a year's study in Germany, he founded a sanitarium in Newton and, soon after, the Wellesley institution. He was a member of the town medical board, the Homeopathic Medical Society, the American Institute of Homeopathy, and the Maudsley Club of Wellesley. He was Chairman of the Wellesley School Committee for ten years and one of the best known residents of the town.